TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Consultants in Pain Medicine

Respondent Name
Travelers Indemnity Co of Connecticut

MFDR Tracking Number
M4-17-1199-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
January 3, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In review of your explanation of benefits, it seems that you denied the claim for code G0479. We feel this was denied in error. All the required information was submitted for the lab testing that was performed as set forth by the Texas Administrative Code."

Amount in Dispute: $130.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0431 reimbursed under this date of service. Further, the Provider failed to submit required documentation with the billing. The Medicare coding edits require that the doctor's order for urine drug screening be submitted with the billing."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 13, 2016	G0479	$130.76	$75.75

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 6578 – Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the comprehensive laboratory code.

Issues

1. Did the requestor raise a new issue with their response?
2. Are the insurance carrier's for denials supported?
3. What is the rule that applies to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "Further, the Provider failed to submit required documentation with the billing. The Medicare coding edits require that the doctor's order for urine drug screening be submitted with the billing." Per 28 Texas Administrative Code §133.307 (d)(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section." The respondent's position was not found on the explanation of benefits and therefore will not be considered in this review.

2. The requestor is seeking reimbursement of Code G0479 – "Drug test(s), *presumptive*, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service" for $130.75 date of service October 13, 2016.

   The insurance carrier denied disputed services with adjustment reason code 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.203 (b) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the adjudicated claim that was paid finds Code G0481 – "Drug test(s), *definitive*, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed."

Based on the descriptions of the services rendered, the Division finds there are two separate services that have no CCI edits. Therefore, the carrier's denial is not supported. The services in dispute will be reviewed per applicable fee guidelines.

3. 28 Texas Administrative Code §134.203 (e) states,

   The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

   (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

   Review of the 2016 Clinical Diagnostic Laboratory Fee Schedule finds so separate allowance for the professional component. Therefore the maximum allowable reimbursement will be calculated per 28 Texas Administrative Code 134.203(e)(1).

   The fee schedule amount found in 2016 Clinical Fee Schedule is $60.60 this amount multiplied by 125% = MAR of $75.75. This amount is recommended.

4. Based on requirements of Rule 134.203 the amount payable is $75.75. The carrier previously paid $0.00. The remaining balance of $75.75 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $75.75.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $75.75, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.